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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,

v.

THE TRAVELERS INSURANCE COMPANY, HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST, NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIAN'S HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,
Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts New York's all-payor hospital reimbursement system to the extent that the system provides, irrespective of ERISA status, one set of rates for patients covered by Medicaid, Blue Cross plans and health maintenance organizations ("HMOs") and another set of rates for patients covered by other third-party payors, including commercial insurers and self-insurerd plans, because different costs may be experienced by ERISA plans based on their choice of coverage.

2. Whether the Federal Employees Health Benefits Act ("FEHBA") preempts New York's all-payor hospital reimbursement system to the extent that the system provides, irrespective of FEHBA, one set of rates for patients covered by Medicaid, Blue Cross plans and HMOs and another set of rates for patients covered by other third party payors.

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the decision of the United States Court of Appeals for the Second Circuit, which is contained in the separately bound joint appendix at pages A-1 to A-2. Because of the numerosity of the parties, the list will not be reproduced herein.

In accordance with the Supreme Court Rule 29.1, Petitioner Hospital Association of New York State states that it does not have a corporate parent or subsidiaries, other than wholly-owned subsidiaries.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Hospital Association of New York State ("HANYS") respectfully petitions this Court for a writ

of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case.

OPINIONS BELOW

The amended opinion of the Court of Appeals for the Second Circuit is not reported. It is reproduced in the separately-bound joint appendix at A-1 to A-34. The decision of the United States District Court for the Southern District of New York is reported at 813 F. Supp. 996 (S.D.N.Y. 1993). It is also reproduced in the appendix at A-63 to A-90.

JURISDICTION

The judgment of the Court of Appeals was initially entered on October 25, 1993. On January 12, 1994, the Court of Appeals granted a petiiton for a rehearing, and on January 14, 1994, the Court of Appeals entered an amended opinion. Pursuant to Rule 13 of the Rules of the Supreme Court of the United States, this petition is filed within ninety (90) days of the date of the amended opinion. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1) (1988).

STATUTORY PROVISIONS INVOLVED

1. The relevant statutory provisions are:

(a) ERISA § 514(a), (codified at 29 U.S.C. § 1144(a) (1988)), which provides that:

> Except as provided in subsection (b) of this section, the provisions of this Subchapter and Subchapter III of this Chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Pub. L. No. 101-508, § 7002(c), 104 Stat. 1388-330 (1990), (codified at 5 U.S.C. § 8909 (f)(1) (Supp. IV 1992)) which provides:

Exemption From State Premium Taxes—Section 8909 of title 5, United States Code, is amended by adding at the end the following:

> (f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(c) N.Y. PUB. HEALTH LAW § 2807-c(1)(a) (McKinney 1993), a copy of which is set forth in the appendix at A-101 to A-102.

(d) N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1993), a copy of which is set forth in the appendix at A-102 to A-103.

STATEMENT OF THE CASE

This action involves a challenge under the Employee Retirement Income Security Act of 1974 ("ERISA") and the Federal Employees Health Benefit Act ("FEHBA") by several commercial insurance companies and their trade associations to the statutory method by which New York State controls inpatient hospital rates for all patients. The Court of Appeals below held that these federal statutes perempted a New York law that created one set of hospital rates for patients covered by Blue Cross, HMOs, and Medicaid, and another (higher) set of rates for patients covered by other arrangements, even though the Court recognized that plans subject to ERISA and FEHBA (like any other consumer) are free to choose either category of coverage. The Court thought it sufficient for preemption under ERISA that the law "purposely interfere[s] with the choices that ERISA plans make for health care coverage," A-22, and that (for plans electing certain kinds of coverage) the law "substantially increase[s] the

cost to ERISA plans of providing beneficiaries with a given level of health care benefits." A-23. It justified preemption under FEHBA on the ground that the differential between the rates charged for hospital services was an impermissible "tax, fee, or other monetary payment . . . with respect to any payment made from the [Federal Employees Health Benefits] Fund." 5 U.S.C. § 8909(f)(1) (Supp. IV 1992).

A. New York's Hospital Reimbursement System

1. *The Overall System*

As part of its effort to assure access to quality health care services (*see* N.Y. COMP. CODES R. & REGS. tit. 10, Part 405 (1993)), and to control health care costs, New York State regulates the rates for in-patient hospital care rendered to all patients, other than those covered by Medicare.[1] N.Y. PUB. HEALTH LAW § 2807-c (McKinney 1993). Under the current rate-setting system, medical procedures are divided into categories known as diagnostic related groups ("DRGs"), based on a patient's medical diagnosis. Each DRG category is then assigned a different "case based" rate which, as described below, depends on numerous factors. The theory behind these case based rates is that paying hospitals a fixed amount per condition gives them an incentive to control costs and to use their resources efficiently.

While the DRG categories are the same for all hospitals, the actual case based rate for each diagnosis varies from hospital to hospital. The reason is that the particular amounts for each hospital reflect a multitude of factors that are hospital-specific. Those factors include a

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[1] Since Medicare is strictly a federal program, individual states may not set Medicare rates unless they have obtained an express authorization from the United States Department of Health and Human Services. Such an authorization was previously in effect and, between 1985 and 1988, Medicare participated in New York's "all-payor" system.

hospital's historical operating costs, its capital costs, the total number of patients it treats annually, the total number of Medicare patients it treats annually, whether the hospital is a teaching facility, whether the hospital is located in New York City or upstate, and whether the hospital is situated in a rural community.

2. *The 13% Differential*

(i) *Generally*

The DRG categories are the basis for the final case based rates, which are arrived at by computing adjustments to reflect a myriad of hospital-specific factors. New York Public Health Law section 2807-c(1)(a) requires hospitals to bill patients covered by Medicaid, Blue Cross plans and HMOs at the hospital's case based rate. In contrast, New York Public Health Law section 2807-c(1)(b) requires hospitals to bill patients covered by workers' compensation, commercial insurance, the volunteer firefighters' benefit system, the volunteer ambulance workers' system, self-insured plans and the "no-fault" motor vehicle insurance system a different case based rate which is 113% of the Medicaid-Blue Cross-HMO rate.[2] It is this 113% multiplier—which effectively creates a 13% differential between the two sets of rates—that Respondents have sought to invalidate.[3]

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[2] There are patients who do not fall within either of these provisions. For example, patients who are not covered by insurance or who are covered by self-insured funds that do not make direct payments to hospitals fall into a third category under New York Public Health Law section 2807-c(1)(c), and are billed charges for hospital services. Such charges, however, may not exceed approximately 131% of the case based rate that would apply if the patient were subject to section 2807-c(1)(a).

[3] Respondents, commercial insurers and their trade associations, have also challenged a recently-enacted 11% assessment imposed on hospital bills for those patients covered by commercial insurance. 1992 N.Y. Laws ch. 55, § 348. In addition, some of the commercial insurer Respondents as well as the HMO Respondents have challenged a 9% assessment, enacted by the same section, which is

(ii) *History*

The current 13% differential in hospital rates evolved from 14 years of legislation designed to spread the burdens of financing in-patient hospital care fairly among the many payors in the system. Prior to 1978, with the exception of certain mandatory rates applicable to Medicaid and Blue Cross that were based upon a hospital's historical costs, there were no limits on what hospitals could charge patients. The result was that hospital rates were widely disparate with no incentive toward efficiency or cost controls.[4] Accordingly, the State enacted temporary cost containment legislation in 1978 that froze hospital charges to commercially insured patients until a more comprehensive approach was developed.

In 1982, the State enacted its first comprehensive hospital reimbursement statute, called the New York Prospective Hospital Reimbursement Methodology ("NYPHRM I"). That statute included a provision prohibiting hospitals from charging patients more than 12% to 25% above the cost-based rates that applied to Medicaid and Blue Cross plans. These cost controls applied to hospital rates for all patients, including those covered by the federal Medicare program. Recognizing the effectiveness of state regulation in containing health care costs, Congress authorized the Secretary of Health and Human Services to elect Medicare participation in state programs, which the Secretary did with respect to NYPHRM I. 42 U.S.C. § 1395b-1 (1988). Indeed, when Congress substantially reformed Medicare into a prospective rate-setting system in 1983, it reaffirmed the importance of Medicare partici-

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imposed on hospital bills for patients covered by HMOs. HANYS takes no position on the 11% and 9% assessments as they are not used to meet the costs that hospitals must incur. Rather, they are a means to raise revenue for the State. Neither the 11% assessment nor the 9% assessment applies to self-insured funds.

[4] During the mid-1970's, for instance, hospitals' bills for patients covered by commercial insurance were anywhere from 13% to 36% more than bills for patients covered by Medicaid and Blue Cross.

pation in NYPHRM I's system, in particular. *See generally Rebaldo v. Cuomo,* 749 F.2d 133, 136 (2d Cir. 1984), *cert. denied,* 472 U.S. 1008 (1985).

In 1985, NYPHRM I expired and NYPHRM II was enacted, covering in-patient hospital reimbursement from 1986 through 1987. NYPHRM II provided that the difference between cost-based rates and other rates could not exceed 12%.

In 1988, the State enacted NYPHRM III, which governed hospital reimbursement from 1988 through 1990. NYPHRM III changed the reimbursement methodology from a dual charge-based/cost-based system to a single all-payor case payment system, with a 13% differential between the rates for patients covered by Medicaid, Blue Cross and HMOs, and those covered by other third-party payors. In 1990, the State enacted NYPHRM IV, which governed hospital reimbursement from 1991 through 1993. NYPHRM IV continued the all-payor case payment system, including the 13% differential.

The change from a partial cost-based system to an all-payor case payment system was consistent with congressional initiatives toward state regulation of health care costs. At the time Congress was considering changing Medicare into a prospective rate system, it was also encouraging state Medicaid programs, including New York's, to consider abandoning cost-based reimbursement in favor of prospective systems.[5] In addition, realizing that hospitals could shift costs to non-governmental payors in the case of a partial cost-based system, Congress encouraged states to develop all-payor systems.[6] Congress was also

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[5] *See* H.R. REP. No. 158, 97th Cong., 1st Sess., pt. 2, at 293 (1981) ("The Committee is especially interested in the development of prospective rate methodologies as a replacement for the current reasonable cost reimbursement system under Medicaid").

[6] *See, e.g., Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Finance Comm.,* 98th Cong., 1st Sess., pt. 1 at 148 (1983) (Statement of Robert M.

aware that an all-payor system does not mean that all rates must be the same; rather, the system may be structured such that rates may differ among payors.[7]

The rates established by the New York Public Health Law operate without regard to whether the patient is or is not an ERISA plan beneficiary. Neither section 2807-c(1)(a) nor section 2807-c(1)(b) makes any reference

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Crane, N.Y. State Dep't of Health ("[A]n effective cost containment program requires all payers to participate. Otherwise, the primary effect is simply cost-shifting among third-party payers"), and at 209 (Sen. Durenberger) ("In the absence of an all payer-system you don't get that cost-sensitivity because the costs are shifted"); STAFF OF SENATE SPECIAL COMM. ON AGING, 98TH CONG., 1ST SESS., CURRENT DEVELOPMENTS IN PROPECTIVE REIMBURSEMENT SYSTEM FOR FINANCING HOSPITAL CARE (Comm. Print 1983) ("[A]ll-payer systems . . . will have a more significant impact on hospital expenditures . . . because the greater the proportion of hospital revenues controlled, the more the cost-containment potential of the prospective system is increased."); *Administration of Medicare Cost-Saving Experiments: Hearings Before the Subcomm. on Oversight of the House Comm. on Ways and Means*, 94th Cong., 2d Sess. 27 (1976) (Statement of Elmer W. Smith, Social Security Administration) ("[P]rospective payment systems will not be fully viable unless they include all payers. This means that whenever possible we are encouraging and participating in prospective payment systems that include other third-party payers such as Medicaid, Blue Cross and commercial insurers").

[7] This congressional recognition is established by a 1987 report to Congress by Otis R. Bowen, M.D., then Secretary of Health and Human Services. (Otis R. Bowen, M.D., Department of Health and Human Services, *Report to Congress: The Relationship of Medicare PPS to All Payer Systems and Cost-Shifting*, No. 87-1, at II-47 to III-11 (Jan. 1987)).

> "In establishing rates for all payers, States must decide whether to emphasize equity and establish one rate for all payers or to allow discounts. . ." (*Id.* II-47)
>
> "An important decision in the development of an all-payer system is whether to establish the same rates for all payers or to set a maximum price and allow discounts to be granted in certain cases. Discounts might be granted . . . to reflect charge discounts historically received by certain payers (e.g. BC, Medicaid)" (*Id.* II-53-54).

whatsoever to ERISA plans. Nor does the applicable rate there established depend on ERISA status. Under the system, a hospital will bill a patient covered by Blue Cross the prescribed case payment rate, regardless of whether that patient participates in an ERISA plan. Similarly, a hospital will bill a patient covered by a workers' compensation fund 113% of that case-payment rate, even though such fund is not covered by ERISA.

In addition, the challenged New York statute does not restrict any choice that an ERISA plan may have as to form of coverage—self-insured, commercially insured or Blue Cross. It also does not restrict a plan from choosing to cover, in whole or in part, particular kinds of benefits.

B. Decisions Below

1. *District Court*

Respondent The Travelers Insurance Company initially commenced a civil action against the State defendants seeking, *inter alia*, a declaratory judgment invalidating the 13% differential under ERISA. This was followed by a second action brought by Respondent the Health Insurance Association of America and other insurance trade associations and individual insurance companies also seeking, *inter alia*, a declaratory judgment invalidating the 13% differential under ERISA, as well as under FEHBA. HANYS, the New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield (collectively referred to herein as "Blue Cross") intervened in both actions as defendants. The New York State HMO Conference and Health Services Medical Corporation and eleven individual HMOs then intervened in both actions as plaintiffs. The District Court subsequently consolidated the two actions.[8]

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[8] The District Court's jurisdiction was based on 28 U.S.C. § 1331 (1988).

On February 3, 1993, the District Court granted summary judgment in favor of Respondents, and enjoined the State of New York from enforcing the 13% differential against any commercial insurer or HMO in connection with its coverage of an ERISA plan, or any insurer participating in the FEHBA program. In holding that the 13% differential "relates to" ERISA plans within the meaning of ERISA's preemption provision, the District Court found that the differential imposes a significant economic burden on commercial insurers which provide services to ERISA plans. 813 F. Supp. at 1003. According to the District Court, at least part of this economic burden is then passed on to ERISA plans that have purchased commercial insurance coverage, thereby affecting the structure and/or administration of such plans.[9] *Id.* at 1004-05.

The District Court also held that the 13% differential "relates to" ERISA plans because it diverts ERISA plan resources to a state-specified use which is unrelated to the health care of plan participants. *Id.* at 1004-05. In addition, the District Court concluded that because other hospital rates in other states may not include this cost, the statute creates inconsistent obligations upon multi-state ERISA plans.[10] *Id.* at 1004-05.

With respect to FEHBA, the District Court found that it was unclear under the statute as to whether FEHBA preempts all "taxes, fees or other monetary payments"

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[9] The purported economic cost of the 13% differential to commercial insurers and ERISA plans was vigorously disputed by the parties. This is particularly the case where insured plans pay insurance premiums, not hospital rates. Thus, what effect the 113% multiplier has on premiums is a function of the insurance contract, not the state law. Nevertheless, the District Court made these factual findings, without the benefit of discovery or trial, on a motion for summary judgment.

[10] In addition, the District Court ruled that the 13% differential did not fall within the scope of ERISA's "savings clause," which exempts from preemption state insurance laws. 813 F. Supp. at 1006-08.

that are imposed, directly or indirectly, on a carrier participating in the FEHBA program, or only those taxes, fees or monetary payments imposed on the "premiums" of such carriers. Due to this ambiguity, the District Court deferred to two identical opinion letters issued to the New York State Departments of Health and Insurance by the United States Office of Personnel Management ("OPM"), the agency that administers FEHBA. Although these letters did not specifically address preemption of the 13% differential—dealing only with the more recent 11% assessment—the Court found the letters authoritative with respect to both. The Court also deferred to an amicus brief submitted on behalf of OPM, which did address the 13% differential. *Id.* at 1009-11.

2. *Court of Appeals*

On January 14, 1994, the Second Circuit issued an amended opinion affirming the District Court's holding that ERISA preempts the 13% differential.[11] In ruling that the 13% differential "relates to" ERISA plans, the Second Circuit found that while the challenged statutes did not refer to ERISA plans, they satisfied "the less stringent 'connection with' standard" set forth in *Ingersoll Rand Co. v. McClendon*, 498 U.S. 133 (1990). A-22. The Court reasoned that the 13% differential "purposely interfere[s] with the choices that ERISA plans make for health care coverage" by making Blue Cross coverage more competitive than other health care coverage. *Id.*

The Second Circuit also stated that the 13% differential substantially increases the cost to ERISA plans of

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[11] On October 25, 1993, the Second Circuit issued its opinion affirming the District Court's holding that ERISA preempts the 13% differential. The Second Circuit's decision did not address the District Court's FEHBA holding. On or about November 5, 1993, HANYS and the other Petitioners petitioned the Second Circuit for a rehearing with a suggestion for a rehearing *en banc*. Those petitions resulted in the amended opinion.

providing beneficiaries with a given level of benefits, thus forcing ERISA plans either to increase plan costs or to reduce plan benefits. A-23. In response to Petitioners' contentions that the Supreme Court has never held that an indirect economic impact alone is sufficient to justify preemption, the Second Circuit cited a Southern District of New York decision, *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 WL 51146 (S.D.N.Y. Feb. 23, 1993) for the proposition that a substantial economic impact, standing alone, could be enough to cause preemption. A-24.

On the challenge under FEHBA, the Circuit Court ruled that FEHBA's preemption provision was not limited to State premium taxes. Instead, according to the Court, the provision applies to a monetary payment imposed on a carrier with respect to any payment from the FEHBA fund. Since the Circuit Court held that the 13% differential constituted a monetary payment imposed on such a carrier, it held that the 13% differential was also preempted under FEHBA. A-12 to A-17.

Following the Second Circuit's amended opinion, HANYS, the State and Blue Cross each moved the Court for a stay of its mandate pending application for a writ of certiorari. On February 7, 1994, the Circuit Court granted these respective motions.

REASONS FOR GRANTING THE WRIT OF CERTIORARI

This decision warrants review for several reasons. First, insofar as the Second Circuit found preemption under ERISA, it put itself in direct conflict with a decision of the Third Circuit, holding that a virtually identical provision of New Jersey law was not preempted by ERISA. *See United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382, 383, *reh'g denied*, 114 S. Ct. 651 (1993). In rejecting the challenge, the Third Circuit held that ERISA did not preempt "a statute of general applicability that is designed to establish the prices to be paid for hospital services which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans." *Id.* at 1193. The Second Circuit expressly "decline[d] to follow" this reasoning. A-24 n.3.

Second, these issues are of considerable importance. New York is now barred from exercising the regulatory authority allowed to neighboring New Jersey. Furthermore, all states are in the quandary of not knowing whether—or in what manner—they can carry out traditional police powers of regulating hospital services and controlling health care costs. The result also seriously impedes federal cost-containment objectives.

Third, the Second Circuit's decision expands preemption beyond reasonable bounds. The New York law is indisputably a law of general application that makes no distinctions whatsoever with respect to ERISA plans. To the extent that ERISA plans may have an incentive to choose a particular form of coverage (*e.g.*, Blue Cross), they stand in exactly the same footing as everyone else. The New York law thus "relates to" ERISA plans—in the words of the ERISA preemption provision—only in the sense that *any* general law regulating rates "relates to" a

plan: that is, by subjecting the plan to burdens and benefits like others similarly situated. That has not been, and should not be, grounds for preemption of state law. *See Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988). The decision below, however, is now being interpreted as finding that economic impact, alone, is sufficient for ERISA preemption (*see New England Health Care Employees v. Mount Sinai Hosp.*, 2:92-CV-1012 (JAC) (D. Conn. Feb. 25, 1994)).[12]

Finally, the Second Circuit was mistaken in finding preemption under FEHBA. A hospital rate established pursuant to state law is not a "tax, fee, or other monetary payment . . . with respect to any payment made from the Fund"; rather, it is, like many other charges, simply a basis for calculating the proper charge for a service covered by the Fund. This natural reading of the statutory language is confirmed by the legislative history, which demonstrates quite clearly that Congress intended to preempt imposition of state premium taxes, in whatever form, but not to bar states from subjecting programs to generally applicable rates. The holding below to the contrary, like the holding finding preemption under ERISA, thus erects a wholly unwarranted barrier to the ability of states to subject all consumers of hospital services to important regulatory controls.

I. THERE IS A DIRECT CONFLICT BETWEEN TWO CIRCUIT COURTS WITH RESPECT TO AN ISSUE OF CONSIDERABLE IMPORTANCE

A. Conflict Between Two Circuit Courts

The decision of the Second Circuit in this action is in direct conflict with the Third Circuit's decision in *United Wire, supra.* While the Second Circuit held that ERISA preempts the 13% differential under New York's hospital

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[12] For the Court's convenience, twelve (12) copies of the *New England Health Care Employees* slip opinion have been lodged with the Clerk of the Court.

reimbursement system, the Third Circuit held that ERISA did not preempt a 13.2% differential under New Jersey's hospital reimbursement system. For all intents and purposes, the 13% differential under New York law is indistinguishable from the differential under New Jersey law, given that they both represent the spread between the hospital rates paid by certain high-volume payors, such as Blue Cross, which provide open enrollment policies, and those paid by other payors. The results in the two cases are thus irreconcilable.

Essentially, the two Courts reached these conflicting results due to diametrically opposed analyses of the significance under ERISA of an economic impact upon ERISA plans. The Second Circuit held that the 13% differential "relates to" ERISA plans because it purposefully imposes an economic impact on ERISA plans that have coverage other than Blue Cross. A-23. According to the Court, this economic impact, in turn, impermissibly forces ERISA plans "to increase either plan costs or [sic] reduce plan benefits." *Id.*

The Third Circuit, in contrast, held that the cost of the differential to ERISA plans under New Jersey law was irrelevant because an indirect economic impact, alone, is insufficient to justify preemption. The Third Circuit reasoned that the differential's economic impact was no different from a variety of state regulations that increase the cost of goods and services that hospitals consume and pass on in hospital costs, such as utility costs, wages and waste disposal costs. 995 F.2d at 1193. Under that analysis, the significant issue for the Third Circuit was not the amount of indirect costs imposed by the New Jersey law, but whether that law encroached on the affairs of ERISA plans in any concrete manner. And, in that respect, the Third Circuit concluded that:

> New Jersey's scheme [did] not direct ERISA plans to structure their benefits or conduct their internal

> affairs in any particular way. Nor [did] it deprive ERISA plans of any alternative they would otherwise have in these areas.

Id.[13]

The Second Circuit noted the Third Circuit's decision, but expressly stated that it "reads ERISA's preemption clause too narrowly" and declined to follow it. *Id.*[14]

B. Issues of Considerable Importance

The issue that divides the Second and Third Circuits is of great significance to a state's ability to exercise a fundamental state police power—the regulation of health care and the control of its costs. *See, e.g., Hillsborough County v. Automated Medical Lab, Inc.*, 471 U.S. 707, 719 (1985) ("the regulation of health and safety matters is primarily, and historically, a matter of local concern").

Pursuant to its traditional police powers as well as a constitutional mandate to protect and promote the health of the inhabitants of New York, the State has enacted laws designed to foster a fair and efficient health care delivery system. *See, e.g.*, N.Y. CONST. Art. XVII, § 3; *People ex rel. Whalen v. Woman's Christian Ass'n*, 377 N.E.2d 725, 727-28 (N.Y. 1978) ("There is no question that the economic regulation of hospital costs . . . ad-

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[13] The Third Circuit also suggested that the plaintiffs' position in *United Wire* was contradictory because it selectively challenged certain components of New Jersey's hospital reimbursement system, but accepted other components of the state rate-setting scheme which also impose an economic impact on ERISA plans. *United Wire*, 955 F.2d at 1196. The Second Circuit did not address this contradiction.

[14] The most recent decision in this area, *New England Health Care Employees, supra*, read the Second Circuit's decision as holding that the differentials relate to ERISA plans, and are preempted, soley because they impose a significant economic burden on plans. Accordingly, the Connecticut district court was bound to reject the Third Circuit's view in *United Wire*, and did so.

vanced the legitimate legislative purposes of promoting health, welfare and safety, all consonant with Section 3 of Article XVII of our state Constitution." As inflationary pressures threatened to compromise this important purpose, New York enacted in 1982 comprehensive legislation to regulate hospital costs. Since that time, the State has developed, with federal approval, an all-payor hospital reimbursement system that seeks to provide hospitals with necessary financial resources while containing costs and spreading them equitably among all payors. This action now threatens New York's ability to achieve these balanced objectives.[15]

Aside from paralyzing New York's efforts to contain spiraling health care costs, the Second Circuit decision will paralyze such efforts of every other state, as well as the federal initiatives that have served as the catalyst for these rate-setting systems. Should a state continue to regulate hospital rates in any form, that state and its hospitals not only face certain litigation, they also face potentially crippling liability.[16] In this regard, commer-

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[15] Indeed, the District Court acknowledged that its holding may mean that New York is prohibited from enacting *any* kind of comprehensive regulation controlling hospital costs. Specifically, the Court stated that:

> Defendants correctly note that to the extent that the Court finds that New York's statutes "relate to" employee benefits plans, then "ERISA preempts all state hospital rate-setting statutes, at least to the extent they apply to rates charged to patients that are paricipants in ERISA plans which include hospital expenses as a benefit." (Defendants' Brief at 25 n.19). This result is obviously undesirable in that it greatly complicates states' efforts to regulate and control hospital costs.

813 F. Supp. at 1006.

[16] In *Capo et al. v. HANYS et al.*, No. 93 Civ. 7996 (S.D.N.Y.), an ERISA plan has used the Second Circuit's judgment as the basis of a class action suit brought on behalf of all employee benefit plans against a class of all general hospitals in New York State seeking to recover all sums paid since 1988 attributable to the 13% differential. The total amount paid by all payors with respect to the differentials since 1988 is a sum estimated to exceed $1.5 billion.

cial insurers and ERISA plans already have construed the Second Circuit's decision as providing them with immunity from any State control of hospital rates. Following the District Court's decision in this action, commercial insurance companies and ERISA plans have brought a litany of ERISA actions seeking to invalidate various other components of state hospital reimbursement systems. *E.g., New England Health Care Employees, et al. v. Mount Sinai Hosp., et al.*, No. 2:92-CV 1012 (JAC) (D. Conn.) (Feb. 25, 1994) (challenging Connecticut's uncompensated care pool)[17]; *Connecticut Gen. Life Ins. Co. et al. v. Cuomo*, No. 93-3648 (S.D.N.Y.) (challenging New York's balance billing law); *Boyle et al. v. Anderson*, No. 3-93-359 (D. Minn.) (challenging Minnesota's methodology of funding care to the uninsured and under-insured); and *Trustees of & the Pension Hospitalization Benefit Plan et al. v. Cuomo et al.*, 92 Civ. 5589 (E.D.N.Y.) (challenging New York's funding of bad debt and charity care).

In addition to precluding a state's ability to achieve its own traditional police power objectives, the Second Circuit decision will impede federal cost-containment policies. For more than a decade, Congress has been encouraging states to enact comprehensive all-payor hospital cost containment legislation. The federal Medicare Act specifically provides that the Secretary of Health and Human Services may elect to reimburse hospitals under Medicare pursuant to comprehensive reimbursement sys-

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[17] In *New England Health Care Employees, supra*, the Connecticut district court, relying in large part on the Second Circuit's ruling, held that ERISA preempts a Connecticut statute designed to compensate hospitals for the cost of providing services to Connecticut's indigent, uninsured and underinsured. That statute required hospitals to include an assessment in their bills to defray the costs of uncompensated care. Citing the Second Circuit's decision, the district court ruled that the economic impact of the Connecticut law on ERISA plans was sufficient to warrant preemption.

tems.[18] Thus, to the extent the Second Circuit's decision interferes with a state's authority to develop an all-payor hospital reimbursement system, it runs contrary to federal cost containment policies.

Finally, the Second Circuit decision gives rise to the broader issue regarding the extent to which states can enact any law regulating the operation of hospitals and other health providers. The Third Circuit in *United Wire* suggested that if the differential in that case were invalidated due to its indirect economic impact, then a host of other state health laws may be preempted because they have some indirect impact on hospital costs. The Third Circuit observed, for example, that state regulation of medical waste disposal would be preempted because it significantly increases a hospital's cost of doing business and, accordingly, its billings to plan participants. *United Wire*, 993 F.2d at 1193. Under the same rationale, laws providing minimum staffing levels for physicians and nurses, record-keeping requirements, construction codes and infection control procedures could also be preempted. *See, e.g.*, N.Y. COMP. CODES R. & REGS. tit. 10, Part 405 (1993). Without clear guidance from this Court, this action will likely spawn challenges to these and other fundamental state health laws, seeking to immunize ERISA plans from any costs associated with those laws.

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[18] *See, e.g.*, 42 U.S.C. § 1395f(b)(3) (1988), which authorizes the Secretary to continue to reimburse hospitals pursuant to a previously approved demonstration reimbursement system until the Secretary determines that "a third-party payor reimburses such a hospital other than under such system. . . ." *See also* 42 U.S.C. § 1395ww(c) (1988), which expands the Secretary's authority to participate in state reimbursement systems beyond a limited demonstration or experimental program, provided the state system reviews "at least 75 percent" of all inpatient revenue. This necessarily envisions state control over all private insurers' rates.

II. THE SECOND CIRCUIT EXPANDED THE SCOPE OF ERISA PREEMPTION

This case represents the first time a Circuit Court decision can be read to hold that ERISA preempts a law of general application simply because it has an indirect economic impact on ERISA plans. If this interpretation is sustained, ERISA plans will lead a "charmed existence that was never contemplated by Congress." *United Wire*, 995 F.2d at 1194, *quoting Rebaldo*, 749 F.2d at 138-39.

New York Public Health Law sections 2807-c(1)(a) and 2807-c(1)(b), the two provisions which create the 13% differential, neither refer nor specifically apply to ERISA plans. To the contrary, these provisions apply to hospital bills of patients covered by third-party payors, irrespective of ERISA status. Section 2807-c(1)(a), for example, requires hospitals to bill patients covered by Blue Cross or an HMO at the case based applicable rate, regardless of whether that coverage is furnished through an ERISA plan. Similarly, section 2807-c(1)(b) requires hospitals to bill patients covered by commercial insurance 113% of the applicable case based rate, whether or not that insurance is purchased by an ERISA plan. In addition, section 2807-c(1)(b) requires hospitals to bill patients covered by, among others, workers' compensation funds and no fault insurance, which are not covered by ERISA, the same rate as patients covered by a self-insured fund, which may be covered by ERISA.[19]

It is significant that these provisions speak to hospital rates for patients, and not to ERISA benefits for ERISA plan participants and beneficiaries. The provisions do not restrict an ERISA plan from determining its form or level of benefits. ERISA plans are free to self-insure,

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[19] Further, hospitals bill patients covered by ERISA self-insured funds that do not make direct payments to hospitals on the basis of charges (i.e. prices) under section 2807-c(1)(c), instead of a case based rate. Thus, patients covered by ERISA plans may fall into any of the three provisions under New York law.

join an HMO, insure through commercial insurance or insure through Blue Cross. And, regardless of the funding method, an ERISA plan is free to determine whether it will cover some, all or none of a participant's medical expenses.

At most, the New York law has an indirect economic impact that affects ERISA plans in the same manner as it affects other consumers and providers of health insurance. This indirect impact is simply insufficient to justify preemption. Otherwise, ERISA plans would be exempt from any state regulation that indirectly affects the cost of doing business, including rent control laws, labor laws and highway tolls.

As recognized by the Third Circuit in *United Wire*, this Court already has rejected such an expansive approach to ERISA preemption. In *Mackey*, this Court ruled that ERISA did not preempt the application of a state garnishment statute to ERISA plans even though it created substantial costs to such plans. This finding is wholly in accord with this Court's long-standing principle that ERISA does not preempt state laws that have "only a 'tenuous, remote, or peripheral' connection with covered plans . . . as is the case with many laws of general application." *District of Columbia v. Greater Wash. Bd. of Trade*, —— U.S. ——, 113 S. Ct. 580, 583 n.1 (1992), *quoting Shaw v. Delta Air Lines*, 463 U.S. 85, 100 n. 21 (1983).

In addition, the Second Circuit failed to consider whether Congress intended for ERISA to preempt generally-applicable state hospital laws, in particular. This is contrary to a line of Supreme Court cases that establish Congressional intent as the "ultimate touchstone" in any preemption analysis. *E.g., Cipollone v. Liggett Group*, 112 S. Ct. 2608, 2617 (1992), *quoting Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978). This line of cases applies the preemption doctrine cautiously in order to prevent federal laws from encroaching onto

traditional state police powers, absent compelling evidence of Congressional intent. *E.g., Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (preemption analysis "start[s] with the assumption that the historic police powers of the States [are] not to be superseded . . . unless that [is] the clear and manifest purpose of Congress"); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981) (the need for unmistakable Congressional intent is "guided by respect for separate spheres of governmental authority preserved in our federalist system").

Given these cases, this decision cannot stand. In determining whether Congress intended to preempt state regulation of health care costs and charges, it is necessary to examine what Congress has said, and legislated, on both employee benefits and health care. *United Wire* undertook such a dual analysis; the decision below did not. While paying heed to Congress' intent to broadly preempt state laws under ERISA, the Second Circuit simply ignored twenty-five years of Congressional legislation and encouragement of state efforts to regulate hospital costs and the development of all-payor reimbursement systems to equitably apportion those costs.

III. THE SECOND CIRCUIT WRONGLY CONCLUDED THAT FEHBA PREEMPTS NEW YORK LAW

The Second Circuit's finding of preemption under FEHBA suffers from the same faulty reasoning employed in its ERISA analysis, i.e., a presumption that a state rate-setting statute of general application is preempted because a component of that rate has an economic impact upon plans. Thus, the same considerations, other than conflict among circuits, that compel granting of the writ of certiorari for ERISA preemption issues apply for the FEHBA issue. The uncertainty created by the Second Circuit's ruling on FEHBA is appropriate for resolution by this Court. For the following reasons, that ruling is also erroneous.

FEHBA does not preempt a state law of general application that regulates hospital rates. FEHBA section 8909(f)(1) prohibits any tax, fee or monetary payment imposed with respect to any payment from the FEHB Fund; it does not preempt a payment from the Fund itself. New York Public Health Law sections 2807-c (1)(a) and 2807-c(1)(b) merely determine the amounts that hospitals must bill patients for their services. The 113% multiplier is not a tax on the payment of the bill, it is one step in the calculation of what that bill will be. Thus, these provisions simply set the rates upon which the Fund determines what it will pay for hospital services, and they do not constitute any extra fee, tax or monetary payment on such rates.

Moreover, FEHBA's legislative history and regulations indicate that the statute preempts only state premium taxes. The House Report to the FEHBA bill stated that "[i]n order to meet the savings targets charged to the Committee, the legislative language exempts the [FEHBA Program] from *state premium taxes*. . . ." H.R. REP. No. 881, 101st Cong., 2d Sess. 173 (1990) *reprinted in* 1990 U.S.C.C.A.N. 2017, 2181 (emphasis added). Similarly, the Senate Report stated, in relevant part, that:

> Under current law, FEHB insurance carriers are required to pay state premium taxes. These taxes are built into the program's premium base. Exempting carriers from paying this tax would result in a premium reduction (which of course, reduces the government's share) . . . .

136 CONG. REC. S15,715 (daily ed. Oct. 18, 1990, pt. 1). Moreover, FEHBA regulations indicate that the statute's preemption provision is directed at premium taxes:

> 5 U.S.C. § 8909(f) . . . applies to all forms of direct and indirect measurements *on FEHBP premiums*, however modified, to include cost per contract or enrollee, with the sole exception of a tax on net income

> or profit, if that tax, fee, or payment is applicable to a broad range of business activity.

48 C.F.R. § 1631.205-41 (1991) (emphasis added). The Second Circuit improperly deferred to non-binding OPM opinion letters that recited OPM's belief that FEHBA preempts the 11% state assessment imposed on commercial insurers,[20] rather than to the agency's own duly-promulgated regulations.

Congress expressly delegated to OPM the authority to promulgate regulations necessary to execute FEHBA's provisions. 5 U.S.C. § 8913(a) (1988). In its final regulations "to implement the State premium tax provisions of section 7002(c) of Public Law 101-508," 56 Fed. Reg. 57,496 (Nov. 12, 1991), OPM explained: "This legislation exempts Federal Employee Health Benefits (FEHB") Program carriers, underwriters, and plan administrators *from State taxes on FEHB premiums.*" *Id.* (emphasis added).

OPM's regulations prohibiting payment of State premium taxes are legislative rules. *See General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984). They were promulgated to implement the FEHBA preemption provision pursuant to an express delegation of authority, they use mandatory language to declare state premium taxes "unallowable costs," and they require that all FEHB contracts based on cost analysis include a clause incorporating OPM's definition of "premium taxes" into their text. 48 C.F.R. § 1652.216-71(b)(2)(iv)(B) (1992). Because the regulations are legislative rules, they have the force of law, and are binding upon the agency which promulgated them. *E.g., United States v. Nixon*, 418 U.S. 683, 695-96 (1974); *Morton v. Ruiz*, 415 U.S. 199, 235 (1974). Therefore, OPM's opinion letters and any other interpretive materials which contradict the regu-

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[20] These letters rendered no opinion on the 13% differential. Nevertheless, the Second Circuit deferred to the opinion letters as if they had.

lations are invalid so long as the regulations are in effect. *National Medical Enters. v. Bowen*, 851 F.2d 291, 293-94 (9th Cir. 1988). ("A regulation has the force of law; therefore, an agency's interpretation of a statute in a manner inconsistent with a regulation will not be enforced.") It was error, therefore, for the Second Circuit to defer to the opinion letters, and not to the regulations themselves.

CONCLUSION

It is respectfully requested that this Court grant HANYS' petition for a writ of certiorari.

Respectfully submitted,

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